Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HealthTrust

Respondent Name
Ace Fire Underwriters INS Co

MFDR Tracking Number
M4-13-2326-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier gave preauthorization for the individual psych office/outpatient and has denied both dates of service twice stating the services were not "medically necessity." At this point HealthTrust is left with no other choice but to file for MDR hearing."

Amount in Dispute: $3,880.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, we sent this date of service back for reconsideration and it was determined that an additional allowance is due in the amount of $400. Attached is a copy of the payment information and an updated EOR.

Response Submitted by: ESIS South Central WC Claims, P.O. Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2012 May 2, 2012 May 20, 2012	97799-CP	$3,880.00	$200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 222 – Charge exceeds Fee Schedule allowance
   - 437 – Chronic Pain Management Program
   - ANSIW1 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - 18 – Duplicate Claim/service
   - 148 – This procedure was previously reviewed.

Issues

1. Did the requestor support additional payment is due?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier reduced the disputed services as 222 – "Charge exceeds Fee Schedule allowance." 28 Texas Administrative Code §134.204(h)(5) states in pertinent part, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill… (B) Reimbursement shall be $125 per hour. 28 Texas Administrative Code §134.204(h)(1)(B) states, "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." Review of the submitted documentation finds;

Date of Service in Dispute	Submitted Code from DWC 60	Billed Charges from DWC 60	Allowed Amount per Rule 134.204	Paid Charges	Amount Due
March 20, 2012	97799-CP	$1,560.00	$125 @ 80% = $100 x 8 units = $800.00	$600.00	$200.00
May 2, 2012	97799-CP	$1,560.00	$125 @ 80% = $100 x 8 units = $800.00	$800.00	$0.00
May 20, 2012	97799-CP	$1,560.00	Not eligible for review. No claim copy submitted		
				TOTAL	$200.00

The carrier's reduction is not supported.

2. Review of the submitted documentation finds that Division reimbursement guidelines for Chronic Pain Management were not met. Additional reimbursement can be recommended for dates of service March 20, 2012 and May 2, 2012. However, DWC 60 lists May 20, 2012 as date of service but file contained no claim or Explanation of Benefits with that date of service. These charges are not eligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $200.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $200.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 2, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.